

Date: September 12, 2002
To: Family Care Pilots
From: Monica Deignan, Family Care Project Manager
Center for Delivery Systems Development
Subject: Processing a Family Care Level of Care Change

****This memo updates and replaces a memo on the same subject dated July 26, 2002****

This memo describes the circumstances and timing for changing level of care either during the first 60 days of enrollment, either by the CMO or resource center, or after a change of condition screen is completed. It also provides some guidance about when the CMO may want to ask the resource center to do a re-screen, and when a change of condition screen should be done.

This memo also describes the high-level processing of level of care changes for Family Care CMO members. An example is given of a change that increases the level of care from intermediate to comprehensive or comprehensive nursing home. Examples are also given of instances when changes occur that decrease the level of care, broken into three categories -- Medicaid (MA) eligible, losing MA eligibility and non-MA. An explanation is given of how non-MA intermediate members will be listed on enrollment and remittance and status reports. This memo is not intended to dictate Economic Support (ES) and CARES processing of level of care changes; it is intended to explain to the Family Care programs how a level of care change will be reflected in MMIS capitation payments and MA and Family Care eligibility.

Policy Statements

The processes described below operationalize the following policies:

- 1) Changes in level of care are effective on the date the new level of care is calculated electronically on the new LTC functional screen.
- 2) If the level of care on the eligibility page of the functional screen changes from comprehensive to intermediate, or from intermediate to comprehensive, the capitation rate will change effective on the date the new level of care is calculated electronically.
- 3) Loss of eligibility for Family Care due to a change in level of care follows the same adverse action logic as for loss of Medicaid eligibility.

LEVEL OF CARE CHANGES ON THE LTC FUNCTIONAL SCREEN

Initial Screens

During the first 60 days of enrollment, as the CMO completes the assessment and care plan, it is expected that the interdisciplinary team may at times have additional information about the member and add that to the new enrollee's screen. At other times the CMO may see significant differences in the person's functioning from what was recorded by the RC on the screen. This could be attributed to a number of factors -- the screen may have been done during a post-acute episode when functioning was extremely poor for a short period of time, or the person may have dementia that causes functioning to vary dramatically from day to day. In these types of situations, the RC screener should use the notes section of the screen to explain to the CMO the circumstances under which the screen was filled out. If there is no reasonable explanation available to the care manager at the CMO regarding the difference in functioning of the person, consideration should be given to sending the screen back to the RC and asking for a re-screen. This could provide an opportunity for quality improvement for the RC.

Circumstances that would warrant a request for re-screening include:

- The RC screener marked a target group that does not meet the federal definition for such a target group (ex. marking frailties of aging when the person has no diagnoses to substantiate it);
- The RC screener checked off diagnoses that have not been substantiated or verified by the person's health care provider;
- The RC screener checked needs for health-related services that have not been substantiated or verified (i.e. checking nursing assessment when the person is not cognitively impaired, has few health related needs and no history of either receiving or needing a nursing assessment).

Whether the CMO adds information to the initial screen or the RC does a re-screen during the first 60 days of enrollment, it is still considered an initial screen so the type of screen does not change.

The date of the new level of care is the date the eligibility is recalculated electronically. The level of care change is not retroactive to the date of enrollment. This new level of care should be communicated to ES staff who will change CARES data accordingly.

Change of Condition Screens

A change of condition screen should be completed whenever the interdisciplinary team believes the member's functioning improves or deteriorates significantly. Significant change is defined as increases or decreases in either task or frequency on the health-related services page, or increases or decreases in function in the ADLs, IADLs, or cognition. A change of condition screen may occur any time after the initial assessment and care plan is completed, not during the first 60 days of enrollment. Examples of significant changes are:

- A member has a stroke which results in an increase in the number of ADLs and health-related services he or she needs assistance with;
- A member has had a stroke in the past, but now shows significant improvement in ability to perform ADLs, IADLs and health-related services more independently;
- A member has attended activities of daily living classes and picked up additional life skills such as working independently without a job coach, being able to fix simple meals etc., thus improving his or her ability to perform IADLs;

- Due to loss of function, including cognitive functioning, a member moves from independent living to substitute care such as a CBRF or nursing home.

Again, if the level of care changes as a result of the change of condition, the date of the level of care change that should be communicated to ES is the date that the level of care is recalculated on a new electronic screen.

PROCESSING LEVEL OF CARE CHANGES

Level of Care Increase

When a functional screen is completed for a Family Care member and the member's level of care increases from either grandfather or intermediate to comprehensive or comprehensive nursing home, the new level of care and the effective date of the new level of care must be sent to the ES worker. When the ES gets the information, it will be entered into CARES and then updated in MMIS.

The effective date of the level of care change is the date the new level of care is calculated electronically, and the date the CMO will begin to be paid at the new level of care.

For example:

Cassie, who is eligible for MA, is enrolled in the Fond du Lac CMO at the intermediate level of care. On June 6, 2002, a functional screen is completed and level of care recalculated, and she is determined to be at the comprehensive level of care. The eligibility page of the functional screen that includes the new level of care and the effective date is sent to ES for CARES processing. After the information is entered in CARES and updated in MMIS, the CMO will be paid the following:

June 1 - June 5 - 5 days will be paid at the intermediate rate
June 6 - June 30 - 25 days will be paid at the comprehensive rate

Please note: A recoupment of the June monthly capitation claim that was paid at the intermediate rate will have to be completed before both of the partial payments are made.

Level of Care Decrease

1. **MA eligible** - A member is eligible for MA before the level of care decrease and remains eligible for MA after the level of care decrease.

When a functional screen is completed and level of care recalculated for a Family Care member and the member's level of care decreases from either comprehensive or comprehensive nursing home to intermediate, the new level of care and the effective date of the new level of care must be sent to the ES worker. When the ES gets the information, it will be entered into CARES and then updated in MMIS.

The effective date of the level of care change is the date that the level of care was recalculated electronically and the date the CMO will begin to be paid at the new level of care. In this scenario, the member remains MA eligible and therefore continues to be enrolled in Family Care.

For example:

Buck, who is eligible for MA, is enrolled in the La Crosse CMO at the comprehensive level of care. On June 10, 2002, a functional screen is completed and level of care recalculated. Buck is determined to be at the intermediate level of care. The eligibility page of the functional screen that includes the new level of care and the effective date is sent to ES for CARES processing. After the information is entered in CARES and updated in MMIS, the CMO will be paid the following:

June 1 - June 9 - 9 days will be paid at the comprehensive rate

June 10 - June 30 - 21 days will be paid at the intermediate rate

Please note: A recoupment of the June monthly capitation claim that was paid at the comprehensive rate will have to be completed before both of the partial payments are made.

2. **Losing MA eligibility** - A Family Care member whose level of care changes from comprehensive nursing home to either comprehensive or intermediate may lose MA eligibility because he/she is no longer eligible for waiver MA.

Comprehensive Nursing Home to Comprehensive

When a functional screen is completed and level of care recalculated for a Family Care member and the level of care decreases from comprehensive nursing home to comprehensive, the member may lose MA eligibility and remain eligible for non-MA Family Care (assuming that there is not a freeze on non-MA enrollment). The new level of care and the effective date of the new level of care must be sent to the ES worker. When the ES gets the information, it will be entered into CARES and then updated in MMIS (this includes ending MA eligibility in CARES.)

In this scenario, the member is losing MA eligibility and remaining eligible for Family Care as a non-MA member. The CMO will be paid the same rate (comprehensive) for the member before and after the new level of care information is entered in CARES and MMIS.

For example:

Sonny, who is eligible for waiver MA, is enrolled in the Richland County CMO at the comprehensive nursing home level of care. On June 18, 2002, a functional screen is completed and level of care recalculated. Sonny is determined to be at the comprehensive level of care. The eligibility page of the functional screen that includes the new level of care and the effective date is sent to ES for CARES processing. The ES worker will end MA eligibility following adverse action logic, in this case that would be July 31, leaving Family Care eligibility and enrollment at the comprehensive level of care. After the information is entered in CARES and updated in MMIS, the CMO will be paid the following:

June 1 - June 30 - a monthly cap claim will be paid at comprehensive rate

July 1 - 31 - a monthly cap claim will be paid at the comprehensive rate

July 31 - Last day of MA eligibility. FC eligibility and enrollment continues.

August 1 and forward – a monthly cap claim will be paid at the comprehensive rate

Comprehensive Nursing Home or Comprehensive Intermediate

When a functional screen is completed for a MA-eligible Family Care member and the member's level of care decreases from comprehensive nursing home or comprehensive to intermediate, the member may lose both MA eligibility and Family Care non-MA eligibility. The new level of care and the effective date of the new level of care must be sent to the ES worker. When the ES gets the information, it will be entered into CARES and then updated in MMIS.

In this scenario, the member is losing MA eligibility and Family Care eligibility due to the level of care change. The ES worker will end Family Care eligibility according to adverse action logic. The CMO will be paid the intermediate rate from the effective date of the level of care change (the date the new level of care is electronically calculated) until the eligibility end date entered in CARES and MMIS.

For example:

Orson, who is eligible for waiver MA, is enrolled in the Portage CMO at the comprehensive nursing home level of care. On June 20, 2002, a functional screen is completed and level of care recalculated. Orson is determined to be at the intermediate level of care. The eligibility page of the functional screen that includes the new level of care and the effective date is sent to ES for CARES

processing. The ES worker will enter the level of care and effective date and end MA and Family Care eligibility following adverse action logic, in this case that would be July 31. After the information is entered in CARES and updated in MMIS, the CMO will be paid the following:

June 1 - June 19 - 19 days will be paid at the comprehensive rate

June 20 - June 30 - 11 days will be paid at the intermediate rate

July 1 - 31 - a monthly cap claim will be paid at the intermediate rate

July 31 - Last day of MA eligibility, FC eligibility and FC enrollment

Please note: A recoupment of the June and July monthly capitation claims that were paid at the comprehensive rate will have to be completed before both of the partial payments and the new July capitation payment are made.

3. **Non-MA - Family Care Non-MA** members can only be enrolled at the comprehensive level of care (APS needs members are the exception). A Non-MA Family Care member whose level of care changes from either comprehensive nursing home or comprehensive to intermediate is no longer eligible for Non-MA Family Care.

When a functional screen is completed and level of care re-calculated for a Non-MA Family Care member and the member's level of care decreases from comprehensive nursing home or comprehensive to intermediate, the new level of care and the effective date of the new level of care must be sent to the ES worker. When the ES gets the information, it will be entered into CARES and then updated in MMIS.

In this scenario, the member is losing Family Care eligibility because of the change in level of care. Since the member is losing Family Care eligibility, his/her Family Care eligibility will be ended following adverse action logic.

For example:

Gunther, who is eligible for Non-MA FC, is enrolled in the Milwaukee CMO at the comprehensive level of care. On June 25, 2002, a functional screen is completed and level of care re-calculated. Gunther is determined to be at the intermediate level of care. The eligibility page of the functional screen that includes the new level of care and the effective date is sent to ES for

CARES processing. The ES worker will enter the new level of care and effective date and end Family Care eligibility following adverse action logic, in this case that would be July 31. After the information is entered in CARES and updated in MMIS, the CMO will be paid the following:

June 1 - June 24 - 24 days will be paid at the comprehensive rate

June 25 - June 30 - 6 days will be paid at the intermediate rate

July 1 - 31 - a monthly cap claim will be paid at the intermediate rate

July 31 - Last day of Family Care eligibility and enrollment

Please note: A recoupment of the June and July monthly capitation claims that were paid at the comprehensive rate will have to be completed before both of the partial payments and the new July capitation payment are made.

NON-MA INTERMEDIATE MEMBERS ON ENROLLMENT AND REMITTANCE AND STATUS REPORTS

There will be instances when a Family Care member who is at the intermediate level of care does not have MA eligibility. Two instances of when this would happen are:

1. A member who is MA eligible at the intermediate level of care loses MA eligibility and Family Care eligibility; **or**
2. A member whose level of care has changed to intermediate and is losing both MA and Family Care eligibility.

In both of these instances, the member is not disenrolled from Family Care until adverse action logic will allow, which can be up to a maximum of 1 ½ months after the MA eligibility or Family Care level of care determination.

Identifying Non-MA Members at the Intermediate Level of Care

Enrollment Reports

These members will be in the enrollment report with the MCP 58 (Intermediate level of care report) in the report header. They will have a medical status code of 'FC.'

In September, when the SeniorCare program is implemented, they could have a medical status code of 'FC', 'SC', 'SD', 'SE' and 'SS.'

Remittance & Status Reports

The following procedure codes will be used for Non-MA members at the intermediate level of care:

- Fond du Lac County: N208M - Monthly capitation claim or N208D - Daily capitation claim
- La Crosse County: N328M - Monthly capitation claim or N328D - Daily capitation claim
- Portage County: N498M - Monthly capitation claim or N498D - Daily capitation claim

- Milwaukee County: N408M - Monthly capitation claim or N408D - Daily capitation claim
- Richland County: N528M - Monthly capitation claim or N528D - Daily capitation claim

If there are any questions regarding this memo, please contact Alice Mirk (mirka@dhfs.state.wi.us) at (608) 261-8878 for clinical questions about level of care changes, and Heidi Herziger for questions about processing level of care changes (herzihj@dhfs.state.wi.us) at (608) 267-5054.

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